Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235-1720

Respondent Name
ST PAUL FIRE & MARINE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 5

MFDR Tracking Number
M4-10-2038-01

MFDR Date Received
December 7, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center was under paid per the APC Rate of 130% for CPT Code 63685 which is reimbursed $20,013.23, CPT Code 63655 is reimbursed at $7,040.99… In addition to the CPT Codes, Rev Code 278 (Implants) was under paid per the fee schedule."

Amount in Dispute: $3,208.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider continues to ignore the repeated clarification from the Carrier that this admission was reimbursed pursuant to the contract rate between the Provider and Aetna, the Carrier's provider service contract vendor… With the full contract reimbursement issued under the prior Request for Medical Fee Dispute Resolution, the Carrie contends the Provider is not entitled to additional reimbursement. "

Response Submitted by: William E. Weldon, Staff Attorney for TDI-DWC Services, David Klosterboer & Associates, 1501 S. Mopac Expressway, Suite A320, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2009	Outpatient Hospital Services	$3,208.71	$2,791.21

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- P26N – W3 - ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDTNL INFO RECEIVED FOR THE SERVICE/PROCEDURE, AN ADJUSTMENT HAS BEEN MADE TO THE TTL REIMBURSEMENT OF THE ORGNL INVOICE PER OUR PPO CONTRACT.
- Z014 – 97 - PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE BILLED.
- Z013 – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. THIS BILL HAS BEEN PROCESSED CORRECTLY PER THE STATE FEE SCHEDULE.
- FEES – W1 - WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S. OR IF ON IS NOT SPECIFIED. UCR FOR THIS ZIP CODE AREA.
- INCL – W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PACKAGED SERVICES ARE INCLUDED IN THE APC RATE.
- IMPL – 16 - CLAIM/SERVICE LACK INFORMATION WHICH IS NEEDED FOR ADJUDICATION. NOT DOCUMENTED. INVOICE NEEDED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The respondent's position statement contends that "The Provider continues to ignore the repeated clarification from the Carrier that this admission was reimbursed pursuant to the contract rate between the Provider and Aetna, the Carrier's provider service contract vendor." The insurance carrier reduced or denied disputed services with reason code P26N – "W3 - ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDTNL INFO RECEIVED FOR THE SERVICE/PROCEDURE, AN ADJUSTMENT HAS BEEN MADE TO THE TTL REIMBURSEMENT OF THE ORGNL INVOICE PER OUR PPO CONTRACT." Review of the submitted information found insufficient evidence to support that the services in dispute are subject to a contracted fee arrangement. Pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available" and Texas Labor Code §413.011(d-3), which states, in pertinent part, that "An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review"; on January 20, 2010, the Division requested the respondent to provide "A copy of the fully executed contract accessed for the services in dispute." The respondent did not provide copies of the requested information. The above denial/reduction reason is not supported. Pursuant to §133.307(e)(1) and Texas Labor Code §413.011(d-3), which states, in pertinent part, that "the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: (1) is not provided in a timely manner to the division on the division's request," the disputed services will be reviewed for payment based on the available information in accordance with applicable Division rules and fee guidelines..
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $155,675.00. Accordingly, the facility's total billed charges shall

be reduced by this amount for the purpose of calculating any outlier payments below.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 63685 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0222, which, per OPPS Addendum A, has a payment rate of $15,566.65. This amount multiplied by 60% yields an unadjusted labor-related amount of $9,339.99. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $9,168.13. The non-labor related portion is 40% of the APC rate or $6,226.66. The sum of the labor and non-labor related amounts is $15,394.79. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.24. This ratio multiplied by the billed charge of $6,900.00 yields a cost of $1,656.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $15,394.79 divided by the sum of all APC payments is 73.59%. The sum of all packaged costs is $1,863.19. The allocated portion of packaged costs is $1,371.17. This amount added to the service cost yields a total cost of $3,027.17. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $15,394.79. This amount multiplied by 130% yields a MAR of $20,013.23.

   - Procedure code 63655 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0061, which, per OPPS Addendum A, has a payment rate of $5,476.61. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,285.97. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $3,225.51. The non-labor related portion is 40% of the APC rate or $2,190.64. The sum of the labor and non-labor related amounts is $5,416.15. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.24. This ratio multiplied by the billed charge of $6,900.00 yields a cost of $1,656.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $5,416.15 divided by the sum of all APC payments is 25.89%. The sum of all packaged costs is $1,863.19. The allocated portion of packaged costs is $482.40. This amount added to the service cost yields a total cost of $2,138.40. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $5,416.15. This amount multiplied by 130% yields a MAR of $7,041.00.

   - Procedure code 95972 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0692, which, per OPPS Addendum A, has a payment rate of $109.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $65.54. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $64.33. The non-labor related portion is 40% of the APC rate or $43.70. The sum of the labor and non-labor related amounts is $108.03. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $108.03. This amount multiplied by 130% yields a MAR of $140.44.

   - Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the

separate implantables include:

- "ADV-BIO LEAD ARTISAN 50" as identified in the itemized statement and labeled on the invoice as "ARTISAN SURGICAL LD 50CM 16 CONTACT LEAD" with a cost per unit of $6,690.00
- "BSTN-SC GENERATR IPG" as identified in the itemized statement and labeled on the invoice as "PRECISION IPG KIT DUAL ARRAY RECHRGABLE KIT" with a cost per unit of $19,930.00
- "BSTN-SC PT CHARGING KIT" as identified in the itemized statement and labeled on the invoice as "CHARGING SYSTEM USA" with a cost per unit of $3,230.00
- "BSTN-SC REMOTE CONTROL" as identified in the itemized statement and labeled on the invoice as "SCSII PAT,PRGRAMMING KIT USA" with a cost per unit of $1,285.00
- Per §134.403(b)(2), "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. The health care provider billed for a "BSTN-SC TUNNELER" as identified in the itemized statement and labeled on the invoice as "LONG TUNNELING TOOL." Review of the submitted documentation finds insufficient documentation to support that this item was implanted or meets the definition of an implantable under §134.403(b)(2). Separate reimbursement is not recommended.

The total net invoice amount (exclusive of rebates and discounts) is $31,135.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $2,000.00. The total recommended reimbursement amount for the implantable items is $33,135.00.

5. The total recommended payment for the services in dispute is $60,329.66. This amount less the amount previously paid by the insurance carrier of $57,538.45 leaves an amount due to the requestor of $2,791.21.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,791.21.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,791.21, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.